



## Highlights from this issue

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Ian K Maconochie, *Deputy Editor***Do EPs change their clinical behaviour in the hallway encounters or when a companion is present? A cross-sectional survey and the commentary by Jacky Hanson and Kirsten Walthall**

Privacy is a key element in the process of undertaking a consultation with a patient, as it allows due care and attention to be paid to the patient's condition and to their concerns.

This survey (*see page 406*) was conducted at the 2015 American College of Emergency Physicians Scientific Assembly, by inviting practising ED physicians into a booth at this meeting; participants were asked to consider 22 items to determine if seeing patients in the corridor ('hallway encounters') had any impact on practice including any delay or diagnostic failure, and if yes, then to provide greater detail about the associated problems encountered. Within this survey, physicians were also asked if the presence of a companion altered the nature of the consultation with the patient.

The 409 emergency physicians (EP) answered the survey, with 78% saying that they differed from their usual clerking when seeing patients in the hallway, and 80% revealed that they did so if there were another person attending with the patient. The majority of EP changed their examination practice in the corridor (90%) or when there was another person present (77%), increasing the occurrence of delays or diagnostic error, (OR was significantly increased, 2.34, 95% 1.33–4.11), these being more likely to happen patients who had suicidal conditions, or who were victims of domestic violence or child abuse, and in other forms of abuse such as elderly abuse and substance abuse.

A companion may be helpful during a consultation especially if the patient has significant difficulty with communication, for example, in paediatric cases when most often a parent(s) or carers have to speak on behalf of the non-verbal patient. Other patients with limited communication ability may also benefit from having another person

giving relevant information; the clinician has to judge the value of such information given by the companion and use it in context of the clinical picture. There may be times when additional information may be sought from other sources, especially if there are contradictory elements of the history from the examination that takes place. Such contradiction should give rise to concern about the patient and their circumstances.

The use of the hallway as a clinical area, as the authors in the accompanying commentary highlight (*see page 404*), is reflective of a broken system and is held by most clinicians to be unacceptable, although that it is an increasingly common occurrence in many countries around the world. This paper adds to the notion that such practice leads to poor patient outcomes as well as being a cause of stress and concern to all who work in such EDs.

**Essential medicines for emergency care in Africa**

This paper (*see page 412*) describes a multi-step consensus process to produce an essential medicine list (EML), following review of international emergency lists and after a search of the relevant scientific literature. Two hundred and thirteen medicines were determined to be essential which included 25 not in the WHO list. To help with implementation, the medications in the EML for Africa were divided into essential or desirable, further subdivided according to the needs of the different types of medical facilities.

This work is hugely important in setting current medication requirements for acute and emergency care in Africa, with a pragmatic consensus approach that fits to the needs of different medical settings.

**End-tidal carbon dioxide (etCO<sub>2</sub>) output in cardiopulmonary out of hospital resuscitation – manual versus mechanical – a case series**

This study (*see page 428*) looked at differences in a 'quality' measure of CPR, namely etCO<sub>2</sub> level between these modes of chest compression. The etCO<sub>2</sub>

level indicates if the forces being delivered by hand(s) or by machine are sufficient to maintain pulmonary circulation, allowing gaseous exchange to occur, with the level being measured during the expiratory phase. However, there is concern about etCO<sub>2</sub> level as a quality measure, as noted by the International Liaison Committee on Resuscitation in the Consensus on Science and Treatment recommendation 2015 (<https://volunteer.heart.org/apps/pico/Pages/PublicComment.aspx?q=459>) which merely suggested that certain levels might assist with predicting the return of spontaneous circulation; the Advance Life Support task force wrote that it was not known about the applicability of this measure across all patients as there is a range of aetiologies causing cardiac arrest, some of which can affect those levels, eg saddle pulmonary embolism. Given those caveats, these patients had manual and then mechanical CPR for 2 min in that order. The result was that the mechanical method was not superior to the manual method.

**Risk stratifying chest pain patients in the ED with commonly used scores along with a single troponin test in predicting Major Cardiac Adverse Events**

The authors examined the value of HEART, TIMI and GRACE in combination with a single contemporary cTn at the presentation of a patient with chest pain in terms of being able to determine major cardiac events at 30 days (*see page 420*). The best scoring system for this outcome with a value equal or greater than three was the HEART score with a sensitivity of > 99.5% and matching negative predictive value. Caveats apply that this was a single site study in an observational study that focused therefore on a discrete population attending a tertiary hospital. Of note, 1.89% of patients in this cohort developed major cardiac events at 30 days – this may not be reflective of the incident of events in other healthcare settings.

